

(b) Preventive primary services which may be paid for when provided by Federally qualified health centers are the following:

- (1) Medical social services.
- (2) Nutritional assessment and referral.
- (3) Preventive health education.
- (4) Children's eye and ear examinations.
- (5) Prenatal and post-partum care.
- (6) Perinatal services.
- (7) Well child care, including periodic screening.
- (8) Immunizations, including tetanus-diphtheria booster and influenza vaccine.
- (9) Voluntary family planning services.
- (10) Taking patient history.
- (11) Blood pressure measurement.
- (12) Weight.
- (13) Physical examination targeted to risk.
- (14) Visual acuity screening.
- (15) Hearing screening.
- (16) Cholesterol screening.
- (17) Stool testing for occult blood.
- (18) Dipstick urinalysis.
- (19) Risk assessment and initial counseling regarding risks.
- (20) Tuberculosis testing for high risk patients.
- (21) For women only.
 - (i) Clinical breast exam.
 - (ii) Referral for mammography; and
 - (iii) Thyroid function test.
- (c) Preventive primary services do not include group or mass information programs, health education classes, or group education activities, including media productions and publications.
- (d) Screening mammography is not considered a Federally qualified health center service, but may be provided at a Federally qualified health center if the center meets the requirements applicable to that service specified in § 410.34 of this subchapter. Payment is made under applicable Medicare requirements.
- (e) Preventive primary services do not include eyeglasses, hearing aids, or preventive dental services.

[57 FR 24980, June 12, 1992, as amended at 61 FR 14657, Apr. 3, 1996]

§ 405.2450 Clinical psychologist and clinical social worker services.

(a) For clinical psychologist or clinical social worker professional services to be payable under this subpart, the services must be—

- (1) Furnished by an individual who owns, is employed by, or furnishes services under contract to the FQHC;
- (2) Of a type that the clinical psychologist or clinical social worker who furnishes the services is legally permitted to perform by the State in which the service is furnished;
- (3) Performed by a clinical social worker or clinical psychologist who is legally authorized to perform such services under State law or the State regulatory mechanism provided by the law of the State in which such services are performed; and
- (4) Covered if furnished by a physician.

(b) If State law prescribes a physician supervision requirement, it is met if the conditions specified in § 491.8(b) of this chapter and any pertinent requirements of State law are satisfied.

(c) The services of clinical psychologists or clinical social workers are not covered if State law or regulations require that the services be performed under a physician's order and no such order was prepared.

[57 FR 24980, June 12, 1992, as amended at 61 FR 14657, Apr. 3, 1996]

§ 405.2452 Services and supplies incident to clinical psychologist and clinical social worker services.

(a) Services and supplies incident to a clinical psychologist's or clinical social worker's services are reimbursable under this subpart if the service or supply is—

- (1) Of a type commonly furnished in a physician's office;
- (2) Of a type commonly furnished either without charge or included in the Federally qualified health center's bill;
- (3) Furnished as an incidental, although integral part of professional services furnished by a clinical psychologist or clinical social worker;
- (4) Furnished under the direct, personal supervision of a clinical psychologist, clinical social worker or physician; and

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(5) In the case of a service, furnished by a member of the center's health care staff who is an employee of the center.

(b) The direct personal supervision requirement in paragraph (a)(4) of this section is met only if the clinical psychologist or clinical social worker is permitted to supervise such services under the written policies governing the Federally qualified health center.

PAYMENT FOR RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES

SOURCE: 57 FR 24976, 24977, June 12, 1992, unless otherwise noted.

§ 405.2460 Applicability of general payment exclusions.

The payment conditions, limitations, and exclusions set out in subpart C of this part, part 410 and part 411 of this chapter are applicable to payment for services provided by rural health clinics and Federally qualified health centers, except that preventive primary services, as defined in § 405.2448, are covered in Federally qualified health centers and not excluded by the provisions of section 1862(a) of the Act.

§ 405.2462 Payment for rural health clinic services and Federally qualified health clinic services.

(a) *General rules.* (1) RHCs and FQHCs are paid on the basis of 80 percent of an all-inclusive rate per visit determined by the fiscal intermediary for each beneficiary visit for covered services, subject to an annual payment limit.

(2) The fiscal intermediary determines the all-inclusive rate in accordance with this subpart and instructions issued by CMS.

(3) If an RHC is an integral and subordinate part of a hospital, it can receive an exception to the per-visit payment limit if the hospital has fewer than 50 beds as determined by using one of the following methods:

(i) The determination of the number of beds at § 412.105(b) of this chapter.

(ii) The hospital's average daily patient census count of those beds described in § 412.105(b) of this chapter, and the hospital meets all of the following conditions:

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(A) It is a sole community hospital as determined in accordance with § 412.92 or 412.109(a) of this chapter.

(B) It is located in a level 8 or level 9 nonmetropolitan county using urban influence codes as defined by the U.S. Department of Agriculture.

(C) It has an average daily patient census that does not exceed 40.

(b) *Payment procedures.* To receive payment, an RHC or FQHC must follow the payment procedures specified in § 410.165 of this chapter.

(c) *Mental health limitation.* Payment for the outpatient treatment of mental, psychoneurotic, or personality disorders is subject to the limitations on payment in § 410.155(c) of this chapter.

[69 FR 74816, Dec. 24, 2003]

§ 405.2463 What constitutes a visit.

(a) *Visit.* (1) A visit is a face-to-face encounter between a clinic or center patient and a physician, physician assistant, nurse practitioner, nurse-midwife, or visiting nurse.

(2) For FQHCs, a visit also means a face-to-face encounter between a patient and a qualified clinical psychologist or clinical social worker.

(3) Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when one of the following conditions exist:

(i) After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment.

(ii) For FQHCs, the patient has a medical visit and an other health visit, as defined in paragraphs (b) and (c) of this section.

(4) *Payment.* (i) Medicare pays for two visits per day when the conditions in paragraph (a)(3) of this section are met.

(ii) In all other cases, payment is limited to one visit per day.

(b) *Medical visit.* For purposes of paragraph (a)(3) of this section, a medical visit is a face-to-face encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, nurse-midwife, or visiting nurse.

(c) *Other health visit.* For purposes of paragraph (a)(3) of this section, an